

US Family Health Plan

Prior Authorization Form for

Pliaglis (lidocaine-tetracaine 7%-7%)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it
to: **Attn: Pharmacy, 77 Warren St, Brighton, MA 02135**

QUESTIONS? **Call 1-877-880-7007**

Step 1 Please complete patient and physician information (please print):

1	Patient Name: _____	Physician Name: _____
	Address: _____	Address: _____
	Sponsor ID #: _____	Phone #: _____
	Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete the clinical assessment:

1. What is the indication or diagnosis ?		
2. Is there a contraindication to the use of another drug from the same drug class as the requested drug or to a drug that is used for the same indication?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No Proceed to question 4
3. What is the reason other drugs are contraindicated?		
	Proceed to question 4	
4. Has the patient experienced significant adverse effects with use of other drugs from the same drug class as the requested drug or with drugs that are used for the same indication?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No Proceed to question 6
5. What other drugs have been tried and what adverse effects did the patient experience?		
	Proceed to question 6	
6. Has the patient experienced therapeutic failure with use of other drugs from the same drug class as the requested drug or with drugs that are used for the same indication?	<input type="checkbox"/> Yes Proceed to question 7 on next page	<input type="checkbox"/> No Proceed to question 8 on next page

Continue to next page

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7. What other drugs have been tried and what was the outcome with their use?	Proceed to question 8	
8. Is there an alternative drug that could be used in this patient , either from the same drug class as the requested drug or a drug that is used for the same indication?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 9
9. What is the reason or explanation for stating there are no alternative drugs that could be used in this patient?	Sign and date below	

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature

Date

[6 March 2019]